504 Accommodation Plan

sample

NAME_____**DOB**_____**DATE**_____

SCHOOL_____**GRADE**_____

] Meets eligibility for 504 services (check all applicable areas)

[ ] caring for one's self	[ ] performing manual tasks	[ ] speaking
[ ] walking	[ ] seeing	[ ] hearing
[ ] breathing	[ ] learning	[ ] working
[ ] other_____		

Eligibility determined by: _____

Areas of concern:_____

Services required (check all that are applicable)

[ ] general education	[ ] interpreter	[ ] transportation
[ ] school nurse	[ ] aide	[ ] vision services
[ ] adaptive P.E.	[ ] occupational therapy	[ ] physical therapy
[ ] counseling	[ ] speech/language services	[ ] other_____

Duration of Accommodation(s)

From_____**To**_____**Annual review date**_____

Annual review (check one)

continue **terminate** **re-evaluate**

Student Name_____

Accommodations

Team Signatures **Position** **Date**

Sample